

Patient Care

Facilities should have the ability to provide quick and easy discharge from a hospital setting.

- Hospitals do not follow the “Short Term Nursing Care Rules” when planning a discharge. They should, by the definition in rule 333.22208, make those first calls to determine the appropriate nursing home placement. This burden is placed on the admission or utilization review staff of the skilled facilities or swing bed facilities to make all of the calls.
- Hospitals call a nursing home and then have to wait to get a call back for denial or acceptance of admission because nursing homes have to review charts, arrange for an admitting physician to accept, wait for the admissions director to call back or whatever.
- Hospitals end up delaying a discharge and end up causing the patient and families to have to wait to learn to where and when the discharge will occur.

Nursing homes “pick and choose” who they will and won’t admit. The more difficult patients (complicated care, expensive care, those requiring special equipment) have longer waits as SNFs debate the admission and then these admissions end up going to a facility as a swing bed because no one else will take them. Then the facilities that accept these individuals end up with a disproportionate provision of care issue trying to deal with the most difficult cases.

Patient Choice

Whatever happened to Patient Choice?

- The “50” mile rule is an arbitrary number. Why not 200? Why not 45? Why not 25? Why is there a limit at all? If the goal was to keep patients in their own community, who decided that someone’s community stretched out over an area of 100 miles?
- Consider the 92 year old lady who has been working all of her life in the small community where she lives. She drives others in her community to doctors appointments and she visits her incapacitated neighbors. She meets with friends and family frequently. Now, she becomes ill. She is hospitalized and it is now the time that others visit her. Most of her friends are in their late 80’s or 90’s and it is difficult but important for them to come. She needs additional skilled care for rehab and she wants to go to the local SNF but there are presently no beds available. She **does not** want to be transferred out of her community and the thought of going 49 miles away is distressing. However, it doesn’t matter what she wants, she is transferred anyway. She leaves the facility and goes home before she is really ready because she feels she has to get back to **her community**.

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March 17, 2011

- Consider the 96 year old man who has worked, lived, paid taxes, and contributed to the well being of his community for all of his life. He was the chairman of the Hospital Board for over 30 years. The accomplishments within his community are heralded by everyone in the state. He becomes ill and is placed in “his” hospital. He requires additional skilled care and learns that he must be transferred to another community against his wishes until a bed becomes available at his local SNF. Was it “fortunate” that he died before having to be sent to someone else’s community?
- While not as significant an issue, “age appropriate” care also becomes a patient choice issue. When you have a younger person who has Medicare for whatever reason and ends up on an expensive treatment such as TPN or has complicated care needs, there becomes a need for consideration of placement based on their status in life. It can be very detrimental to their well being to be placed in a SNF where all other residents are 80 years of age or more when all they need is a short-term stay for the initiation of treatment or rehab and are able to respond much better to the treatment plan because they are in an acute setting instead of a LTC setting. This person either goes home too soon or is unable to go home because their treatment is not a covered benefit in that setting.
- The CMS Operations Manual regarding Swing Beds refers, in rule 483.10, that a patient has many rights, including the right to participate in decisions about care planning. It further states, in rule 483.12(a)(2), that there are only 6 reasons that a facility could transfer a patient and none of them make reference to “because a 50 mile rule or a 5 day rule” exists and a patient must be transferred whether they want to be or not.

Facility Practice

Mackinac Straits Health System (MSHS) has gone from a 99 bed facility, back in the 90’s, to a current capacity of 48 beds. This change has not been to “dupe” the system or “pad” our pockets. The demand, and therefore the census, has decreased over the years and it has been difficult to maintain the 85% occupancy rate.

We have also obtained the services of nursing home consultants in the past who have given us their projections for future Long Term Care demand. The “magic” number for our community was 48 beds. We used this projection to design our new LTC facility that is currently under construction.

Our practice has always been to transfer the Swing Bed patients to a vacated bed in our LTC when appropriate. The difficulty we encounter, and the risk we take, is when we admit a patient to our Swing Bed because there is not a SNF that will accept him (due to expense of care, complicated care needed, or felony record). Most likely this patient is not from our county and when he is ready for transfer because he is no longer skilled or he has run out of skilled days, we may be “stuck” as far as finding a nursing home to transfer him to and we are unable to place him. This can create the disproportionate

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division of care discussed earlier. While some nursing homes are quick to enforce the “50 mile rule” to their advantage, they are not always quick to take their share of difficulties or risks.

Bottom Line

This should be a patient choice issue. This should be a community care issue with the patient defining what constitutes “their community”. This should be a patient rights issue. It appears that the Federal rule acknowledges that but not all of states do.

